# Antiretroviral Therapy and Reproductive Behavior in Nigeria: Marriage and Fertility among People Living with HIV

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## Introduction

As in many parts of the world, access to life-saving antiretroviral drugs (ARVs) is just beginning to become more widely available to people infected with HIV in Nigeria. Africa's most populous country, with more than 130 million people, has an adult infection rate estimated to be between 2.5-5.6 percent, translating into at least three million people currently living with the virus (UNAIDS 2006). The federal government launched a small-scale treatment program in Nigeria in 2001 that enrolled fewer than 10,000 people over approximately four years. In late 2005, in conjunction with the increased support for antiretroviral therapy (ART) provided by international donors such as the Global Fund for AIDS, Tuberculosis, and Malaria and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Nigeria's President Olusegun Obasanjo announced that all people in the country living with HIV who required ART would receive drugs free of charge. The initial goal was to reach 250,000 people by June 2006. While this ambitious target has not been achieved, current estimates are that approximately 72,000 Nigerians are receiving treatment through the scaled-up program, and enrollment continues to expand (NASCP 2006).

This massive scale-up, laudable for enabling people to live with HIV, is also creating a whole range of new possibilities and problems, as those receiving treatment re-imagine and forge their larger life projects. In particular, as people realize that HIV/AIDS is no longer a certain death sentence, they strive to actualize their most important priorities, which in southeastern Nigeria include marriage, fertility, and the fulfillment of social obligations to family and community of origin. Even as ART enables people living with HIV to envision and embark on the life projects of marriage and reproduction that are locally imperative, people face numerous social, ethical, and medical dilemmas as they try to live out their ambitions and live up to social expectations, while also needing to adhere to therapy to stay healthy and alive. Although ART enables people with HIV to hope for and undertake these life projects, it also continues to interfere with them, and achieving these larger goals frequently impinges on people's capacity to stay on therapy, follow recommended treatment regimes, and take adequate precautions to protect others (and themselves) from further infection.

As ART has expanded, attention has begun to turn to the effects of treatment for prevention, and specifically the sexual behavior of recipients (Wilson et al. 2002). Much of this work has been conducted in developed countries and has focused on homosexual men (Ostrow et al. 2002; Stephenson et al. 2003; Stolte et al. 2004). Research in developing countries has mainly addressed risky behavior utilizing quantitative data from surveys (Wilson and Minkoff 2001; Moatti et al. 2003; Wilson et al. 2004; Bateganya et al. 2005). Few studies have considered the sexual behavior of people on ART from the point of view of marital and reproductive goals (Wilson 2001), and little ethnographic research has been conducted on the topic. This paper reports on preliminary ethnographic research conducted among people on ART in southeastern Nigeria, focusing particularly on the intersection between antiretroviral treatment and the crucial life projects of marriage and reproduction. Several emblematic case studies are presented to highlight the key questions and issues that emerge as the scale-up of treatment enables and complicates larger life projects, with implications for both the success of these treatment programs and continued efforts at prevention.

## The Research Context

The findings presented in this paper are the result of several years of work and study by the authors in the southeastern Nigerian city of Owerri, the capital of Imo State. Since 2001, the Federal Medical Centre (FMC) in Owerri has served as the only facility in the region offering ART. The FMC serves not only the entire Imo State, with a population of more than 2.5 million people, but also the neighboring states of Abia and Ebonyi – another five million people – which do not yet offer ART services. The FMC began offering ART to 25 people under a pilot study in 2001 and in 2002 became one of 25 sites offering treatment in the federal government's initial program. The FMC-Owerri enrolled 450 adults living with HIV, and from 2002 through 2005 these individuals received drugs at a highly subsidized rate (less than $10 per person per month). In addition, a few hundred other people were treated using drugs provided by Glaxo-Smith-Kline in an arrangement between the hospital and the pharmaceutical giant. Patients on these drugs paid nearly ten times the cost incurred by those in the government program, but this amount was still far less than the cost of the drugs if obtained in the open market.

In 2006, following the new policy of free drugs and the plans for a massive scale-up, the FMC-Owerri began expanding its government-supported program with a target of 2,000 patients. By July 2006, more than 1,800 people were enrolled, including a new population of pediatric cases. Doctors at the FMC anticipate that 2,000 people will be receiving treatment by the end of the year. In addition, new treatment centers are being planned at other facilities in Imo State, and federal and state hospitals in Abia and Ebonyi states are expected to offer ART in the near future.

The first author (Benjamin Mbakwem) founded the Owerri-based non-governmental organization, Community and Youth Development Initiatives (CYDI), in 2001, with the principal aim of addressing Nigeria's HIV/AIDS epidemic by mobilizing local people and resources to increase effective prevention, offer counseling, and provide care and support for individuals living with the disease. CYDI has worked to organize prevention activities for hard-to-reach populations such as urban non-school youths, created the most prominent and popular center for counseling and information about HIV/AIDS in the city, and helped found the first support group for people living with HIV, called the Association for Positive Care (AsPoCa), which is comprised of dozens of individuals receiving ART through the FMC-Owerri program. The first author has counseled scores of people who are HIV-positive, including dozens who are enrolled in the FMC-Owerri ART program.

The second author (Daniel Jordan Smith) has worked in southeastern Nigeria since 1989, initially as a public health worker based in Owerri for three years, and since 1994 as an anthropologist. He has studied Nigeria’s HIV epidemic since 2000, and in 2004 and 2006 conducted more than 20 extended interviews with people receiving ART through the FMC-Owerri program. He has also interviewed multiple program personnel, including doctors, nutritionists, administrators and counselors who work with people receiving treatment. In 2004, he led the Nigeria component of a five-country comparative ethnographic research project, “Love, Marriage and HIV,” in which the marital and reproductive experiences and plans of people on ART became an important sub-theme of the larger study. The findings and analysis in the paper are the result of the observations, interviews, and experiences of the authors working with HIV-infected people receiving ART. All of the names of the individuals whose cases are described are pseudonyms and aspects of their stories have been disguised to protect their anonymity.

## Love, Marriage and ART

As in many African societies, in Igbo-speaking southeastern Nigeria marriage remains one of the most important individual aspirations and social duties that a person experiences (Ottenberg 1958; Isiugo-Abanihe 1994, 1998; Smith 2001a). For younger unmarried adults who learn they are HIV-positive, the devastation of the diagnosis comes not only from the fear that they will die young, but from the realization that they may die without marrying and having children. The significance of marriage and parenthood is illustrated in the dramatic differences in the burial ceremonies accorded to people who are married with children compared with those who die unmarried and childless. For the former the occasion is grand (though still somber if a person is perceived to have died too young) and the pageantry is elaborate. For the latter there may be great sadness, but there is little pomp and ceremony.

Until the advent of ART, the cliché that HIV/AIDS was not only a physical death sentence but a social death sentence was very much the perceived reality in Nigeria. The nature of the social death sentence came not only from the stigmatization of the disease itself (individuals and families go to great lengths to conceal infection), but from the fact that a life cut short by AIDS was often a life without reproduction – a fact that could not be hidden. With the possibility of treatment and a prolonged life, the most important goals that people receiving ART pursue are the life projects of marriage and childbearing. Although it is possible to achieve one without the other, and although we have separated the discussion of marriage and childbearing for organizational and analytical purposes, as the cases discussed below will show, for many people the desires for marriage and children, and the effort to realize these aspirations, are inextricably intertwined.

For people living with HIV who enroll in ART, the consequences for marriage are multiple, but a number of themes are common. Among individuals who learn they are HIV-positive who are already married, the degree of marital stability, even in cases where couples are sero-discordant, is striking. Although we do not have quantitative data for the entire married population receiving treatment at FMC-Owerri, both our own experiences with this group and the perception of the clinicians who see them regularly suggest that marriage in southeastern Nigeria is extremely resilient in the face of an HIV diagnosis, at least in the context of the possibility for treatment. Anecdotally, we find that women are generally more supportive of their spouses when they are the sero-negative member of a discordant couple than when the situation is reversed. This is not surprising given the social roles and inequalities associated with the sex-gender system in southeastern Nigeria. More striking, however, is our overwhelming overall impression of the degree to which the vast majority of marriages remain stable and supportive in the face of one or both members being diagnosed with HIV. It is important to note that the population that actually seeks therapy may be self-selected in ways that are predicted by a degree of awareness and acceptance of the disease that is different from the larger infected population. Further, the continuing stigma of the disease and widespread misperceptions about the inevitability of transmission mean that it might not be easy for a sero-negative spouse to openly separate from a sero-positive partner on the grounds of HIV infection, as he or she would be assumed to be infected and therefore also discriminated against. Nonetheless, in our view, the resilience of marriage in the face of HIV is best understood in the context of the larger cultural importance of the institution. Indeed, as will be explicated below, for most couples in marriages wherein at least one person is on ART, the primary concern is how to keep their marriages viable – both privately, such as in maintaining a satisfying sexual relationship, and publicly, such as by keeping their HIV status hidden and living up to social expectations to have more children.

For unmarried young adults and for older adults perhaps widowed by AIDS, once the shock of an HIV diagnosis is reduced and the positive effects of ART are experienced in terms of restored health and a psychological realization of a possible future, the desire for and obstacles to finding a marriage partner become the most pressing issues they face. Finding a partner for marriage while taking ARVs creates ethical dilemmas about disclosure, poses impediments to taking the drugs, and generates possible risks to the health for both partners in such relationships. At counseling sessions offered in conjunction with ART patients are made well aware of the medical necessity of strict observance of therapy regimens and the risks to themselves and others if they engage in unprotected sex. But this awareness is complicated and often overridden by the fact that in southeastern Nigeria unprotected sex is commonly seen as both a marker of trust and an expression of a willingness and desire to procreate (Smith 2004). Public health messages about how to keep oneself and others healthy collide with social expectations and conventions about how to conduct a relationship that might lead to marriage.

A young woman named Ifeoma came to the FMC-Owerri in December 2002 desperately sick. She had large ulcers in her mouth. She couldn’t eat and appeared severely wasted. She looked on the verge of death. Ifeoma tested positive for both HIV1 and HIV2 and was immediately started on ART. Over time she recovered remarkably well, to the point where the staff at CYDI often said among themselves that her plump figure and smooth skin were prime examples of the astonishing effects of ARVs, and of the often cited AIDS message in Nigeria that “AIDS no de show for face” (Pidgin English for “you cannot tell if someone has HIV by looking at them”). Ifeoma’s story illustrates some of the typical dynamics that unfold as a person on ARVs begins to reconstruct a life project, looking to marry but struggling with whether or how to reveal her status, and how to take her drugs while in a relationship with a man who does not know that she is HIV-positive.

Before she came to FMC-Owerri so sick in December 2002 Ifeoma had been married and separated from her late husband. Shortly after their first child was born, Ifeoma and her husband had a serious fight that led her to return to her family and her natal community. The separation lasted several months and at a point in time she heard that both her husband and her infant son were sick. Before she could arrange to visit, she learned that they both had died. Rumors circulated that the man died of AIDS. At that time Ifeoma’s mother urged her to get an HIV test, but she refused. She felt perfectly healthy and did not believe that her husband and child had died of AIDS, much less that she could be so healthy and also be infected.

About seven months later she became ill with a fever and diarrhea and went to the hospital. Unknown to her, the hospital conducted an HIV test. She recalled being summoned to the doctor's office, without any of the preparations of pretest counseling. The doctor began by saying things like "you know, in this world man proposes but God disposes" and "some news can appear to be too bad, but over time we realize it's not the end of the world." He then dropped the bomb that she was HIV-positive. Ifeoma reportedly fainted and remembers waking up with water being thrown on her face and a crowd of doctors and nurses surrounding her.

After her CD4 count test and other baseline exams, Ifeoma started on ART. Prior to getting sick and learning her HIV status, she had begun a serious relationship with a young man in a nearby city. When she got sick he did not know of the extent of her illness or her HIV status because she had returned to her natal home. Prior to her illness, Ifeoma and her boyfriend had frequent unprotected sex and the man was encouraging her to get pregnant to "fast-forward" a marriage. He wanted evidence of her fecundity before formalizing their relationship. After learning that she was HIV-positive, Ifeoma felt she could not tell him her status without jeopardizing the relationship. She believed that once he found out he would make inquiries about her past and discover the rumors that her first husband had died of AIDS. This news, she thought, would make him suspect that she began having unprotected sex with him knowing full well that she was HIV-positive. Further, she felt it was impossible to introduce condoms into their sexual relationship given his desire for her to get pregnant. There would be no reasonable way to explain her sudden desire for protection.

Taking her drugs required vigilance to maintain her secret. Each of Ifemoa's three antiretroviral drugs was a separate pill and each had to be taken twice a day. Combined with the various vitamins she also took, it meant that a monthly supply was more than 200 pills. To navigate this problem, Ifeoma managed to take advantage of one aspect of household gender inequality. She hid the pills under the sink in the kitchen – a place, she reported, her boyfriend almost never entered. Further, she would time her dishwashing – a task he never undertook – to coincide with her need to take her medications. In this way she managed to keep her secret and stay on her drugs. At the time that we lost contact with Ifeoma – she moved to the city of Port Harcourt with her boyfriend and planned to try to begin collecting her ARVs there – she was still hoping to get pregnant, marry her boyfriend, and eventually find a way to disclose her status.

For many single people on ARVs issues of disclosure are central to the endeavor of navigating sexual and romantic relationships, and these issues frequently come to a head around proposals and plans for marriage. With the increasing awareness of the risks of HIV in Nigeria many churches, including the Catholic Church, now require couples to undergo HIV tests if they wish to be married in the church. The prospect of being tested before marriage creates great anxieties for individuals who are HIV-positive. People create all kinds of ways to deal with this problem, including using premarital testing as a way to gracefully disclose their infection without revealing that they have previously kept it secret.

The case of Chinyere is illustrative. On World AIDS Day in December 2003 CYDI participated in a radio program to educate the public about voluntary counseling and testing and publicize the availability of ART. Chinyere heard the broadcast and came to CYDI's office in search of help. After crying until she was exhausted she narrated her story. Early in 2003 she went to the hospital very sick. She was admitted at an institution notorious for its unwillingness to treat HIV cases. After a short stay at the hospital a nurse asked her to follow her to the doctor's office. Barely able to walk, Chinyere dragged herself into the doctor's consulting room. As she at down he held up a piece of paper (her lab result) and shouted: "Look at you! The sin of fornication has finally caught up with you! Before I open my eyes I want you out of this building. We don't treat people like you here." Banished from this hospital, she eventually received treatment from another doctor who willingly treats HIV patients. She got well and at that time did attempt to enroll in the FMC-Owerri ART program. For many months Chinyere felt perfectly fine and she put her HIV status out of her mind.

In August, an Igbo man based in Europe whom her family wanted her to marry came home for a visit, partly with the idea of seeing whether Chinyere was the woman for him. In contemporary southeastern Nigeria, young people increasingly choose their own spouses independent of family preferences, often based on an ideal of romantic love, but the role of families in suggesting possible spouses and advocating for (or rejecting) particular unions remains prominent. Igbo men who have migrated overseas are particularly liable to look for help in finding a good girl from home to marry. When Obi came home from Europe he and Chinyere got along well. With his migrant's wealth, they traveled around the country and Chinyere enjoyed his company. Eventually, they started having sex. Just before he was to return to Europe, she fell sick – so sick that she could not even escort him to Lagos for his departure.

When Chinyere arrived at CYDI she was terrified about her future. During Obi's visit things had gone so well that they had initiated the first steps in the traditional marriage ceremony and Chinyere had moved in with her future mother-in-law. CYDI counseled her, helped her get immediate treatment, and eventually aided her in getting enrolled in the ART program. She began to get well physically, but in Chinyere's mind she had bigger problems – the possibility that her HIV infection would derail her marriage. Obi was a wealthy man. He was sending money home to build a big house in his village. Chinyere was handling the money, meaning that she always had cash. Her future mother-in-law liked her. She and Obi seemed to genuinely care for each other. There was the added enticement that she might eventually join her husband overseas. The possibility of losing it all if her HIV status was revealed was petrifying.

Not too long after Chinyere started on her ARVs Obi arranged to have the next steps of the traditional wedding ceremony undertaken in his absence. The traditional wedding, where the two extended families come together to perform the customary rituals, is often completed without one or both of the individuals present, especially in this era of far-flung migration. The plan was that they would also be married in the church when Obi returned to Nigeria. In the week leading up to the traditional ceremony, Chinyere experienced terrible rashes all over her body, a common reaction to nevirapine, one of the first-line drugs in the ARV combination commonly provided in Nigeria's ART program. She came to CYDI frantic about her appearance, worried that someone might guess that she had HIV, and fretting that she couldn't possibly wear a turtleneck at her traditional wedding ceremony, where the bride is expected to dress in the latest fashions. She eventually told her mother-in-law that she had an allergic reaction to an everyday medication and this was the story conveyed to the larger traditional wedding party. Chinyere made it through traditional wedding without her HIV status being discovered, but she still faced the fact that Obi would soon come home for the church wedding, and she had not yet revealed her status to him.

The impending church wedding hastened her dilemma because she and Obi were Catholics and, as mentioned above, HIV tests were required of all couples wanting to marry in the church. Chinyere came to CYDI pleading for assistance either to obtain a fake HIV lab result or find someone who was HIV-negative who could take the test in her name. Rumor has it that in Nigeria fake lab results are commonly sought and sometimes issued to enable church weddings. When she was told that CYDI would not facilitate such a scam, she discussed with her counselor other possibilities. She settled on the idea that she would go together with her fiancé for pretest counseling, pretend it was her first test, and feign horror when her result was revealed. She banked on the hope that Obi would stick by her when her status was revealed now that they were traditionally married, and that she would avoid the worse consequences of his discovering her longer-term deception.

On the appointed day, when she and Obi went for their results, Chinyere fainted dramatically. Her gamble paid off. Although Obi tested HIV-negative, he did not react angrily about her result. He even reinforced the doctor's message that Chinyere could receive treatment and lead a normal life. CYDI staff attributed Obi's seemingly enlightened response to all the time he had spent in Europe, but one can only speculate about the reasons for his tolerance and support. We were not able to interview him. Perhaps the most illuminating aspect of the story is that once Chinyere's status was known Obi became a co-conspirator in figuring out how to get married in the Catholic Church. He could accept his wife's HIV status, but he could not live without the social recognition of a church wedding and he personally arranged to secure a fake result for Chinyere.

Chinyere eventually became pregnant, and with the aid of treatment her child was born HIV-negative. She did not breastfeed the baby boy and again had to invent an explanation to cover her unusual behavior. Over time she lost contact with CYDI, but at last report her marriage remained amicable, her child was healthy, and only she and Obi knew her HIV status. In addition to getting married, the desire for children is one of the most powerful and common aspirations of people on ART as they strive to forge life projects and get back to normal.

**Looking for a Child**

It is hard to exaggerate the importance of childbearing in southeastern Nigeria and throughout much of Africa. As the renowned anthropologist Meyer Fortes (1978) argued quite some time ago, it is "parenthood that is the primary value associated with the idea of family in West Africa" (121).  "Parenthood," Fortes says, "is regarded as a *sine qua non* for the attainment of the full development of the complete person to which all aspire" (1978:125). Having children is not only a means to individual personhood, but also a fulfillment of one's obligations to kin and community. Biological reproduction is also social reproduction. Through marriage and parenthood, one not only reproduces and replaces individuals, one creates and builds the very social networks through which people survive and prosper. Every Igbo person assumes he or she will marry and have children, and childlessness is the highest of calamities. Personal lives are devastated by it and popular culture is obsessed with it.

It this context, it is no wonder that for people on ART one of the predominant aspirations once they begin to feel healthy is to have children. Many people on ART embark on or resume childbearing, but the process is fraught with ethical dilemmas, social obstacles, and potential health consequences. A particularly poignant case exemplifies the social and symbolic importance of children in Igbo society in general and for people living with HIV in particular.

Ukachi was an exceptionally beautiful young woman who periodically attended the Monday ART clinic at FMC-Owerri to collect her drugs. But she did not join the support group and seemed to have little or no interaction with other people on ARVs. After long being noticed but never talked to, she finally approached a CYDI staff member following an educational talk given during the clinic. She was worried that she might be infecting her boyfriend or that she was being re-infected by him. They were hoping to marry and have children and she didn't know what to do.

It turned out that Ukachi was already a single mother. She had a four-year-old son to whom she gave birth long before she had learned she was HIV-positive. Over time, we learned that as a teenager she had fallen in deeply in love with her cousin. In Igbo culture they were absolutely forbidden to marry and their relationship was a deep secret. They fantasized about moving abroad so that they could be together but that was never possible. Although they knew they could never marry, they decided to have a child together as an enduring expression of their love. When Ukachi became pregnant her family pressured her to reveal the father, even beating her for the information, but she never exposed her cousin. Eventually, he married and had children with another woman, but he and Ukachi continue to proclaim their love to each other and he secretly supports her in raising their child.

After several years of pining for her cousin, Ukachi resolved that she too would have to marry and have a family of her own, and she set her mind to that task. She started a relationship with man whom she thought might make a good husband. Several months into that relationship, one of her relatives was in an accident and she traveled to the hospital to donate blood. As part of that process her blood was screened and she was informed that she was HIV-positive. She had never been sick and for several months she tried to ignore the result, continuing her relationship with her boyfriend. Finally, she decided to travel to Owerri to seek a confirmatory test at the FMC. She was indeed HIV-positive. She followed up with more tests and when it was revealed that her CD4 count was low she started on ARVs, even though she had never once felt sick.

All of the information she had learned through post-test counseling and the programs run by CDYI made her fearful that she might be infecting her boyfriend and also apprehensive about whether he might have infected her. He had recently been sick, but passed it off as malaria. She wanted to persuade him to do an HIV test, but didn't know how without making him suspect she was infected. He wanted her to get pregnant before they set a date for marrying, so she was as worried about getting pregnant as about protecting her health. With time, the boyfriend decided they should proceed with the traditional wedding even though Ukachi was not pregnant. Shortly after they married she became pregnant. She stopped coming to Owerri for her drugs and for a long time we lost contact.

Ukachi had moved to the city of Enugu with her new husband and had indeed stopped taking her medication. We only learned this because when she was seven months pregnant she went for antenatal care in Enugu and the clinic said they would not agree to assist her delivery unless she did an HIV test. Faced with the possibility of exposure (her husband still did not know her status), she traveled to Owerri so that she could give birth at the FMC. Once the most beautiful and healthy looking of all the patients in the ART program, Ukachi looked sickly and wasted. She stayed in Owerri long enough to have her baby, but returned shortly thereafter to Enugu. When we asked why she had stopped taking her medication, she said she feared she could not hide or explain all the pills (as patient coming from Enugu – two hours away – she could collect three months of pills, which, including vitamins, would amount to over 600 tablets). Rather than risk facing the consequences of revealing her HIV status and possibly undermining her marriage, she chose to have a child who would solidify the relationship and she stopped taking her drugs, even though these actions posed potentially disastrous health consequences for her and others. It is impossible to understand Ukachi's actions without accounting for the primacy of marriage and reproduction in the socially shared conceptions of why one would care to be alive in the first place.

We have also observed numerous cases where an uninfected spouse who knows his or her partner is HIV-positive nevertheless exerts tremendous pressure to procreate. Nnamdi was a founding member of AsPoCa, the first support group in Owerri for people living with HIV. He learned he was HIV-positive after becoming extremely sick. At the time that he was diagnosed with HIV he tried all kinds of treatments, including various native doctors, but he never improved significantly. When the FMC-Owerri ART program began in 2002 he was one of the first to enroll. He told his wife of his problem immediately – in fact, he had no choice because when he received his result several family members were with him in the hospital and the staff was completely indiscreet, revealing his result to him in front of all the visitors. His wife stuck by him steadfastly. She tested negative for the virus. At the time of his diagnosis they had two young sons.

Nnamdi said that when he was sick he never even thought of sex, much less having another child. But when he became better after beginning ART he and his wife resumed a sexual relationship and Nnamdi reported that he always used condoms. About a year or so after he had started on ART he sought counseling at CYDI because his wife began putting pressure on him to have another child. As a leader of AsPoCa he was well versed in all the most up-to-date information about risks, prevention, and treatment. He said he did not want to put his wife at risk, and he was not inclined to expose her to such risks when they already had two sons. Because of the patrilineal structure of Igbo lineages people (perhaps especially men) are greatly concerned with having sons to pass on their names, land, and property. Normally Nnamdi would have been eager to have another child and happy to have a daughter, but under the circumstances, he said, “I am ok with two sons.”

His wife, Ogechi, was, however, intensely desirous of having a third child. Nnamdi wasn’t sure how to negotiate her increasing insistence so he asked if he could bring Ogechi to CYDI for counseling. At CYDI she was counseled about the risks of unprotected sex for herself and about the possible risks of maternal to child transmission. She knew all these risks already and still wanted to get pregnant. She explained that her friends, peers and relatives had been asking for some time why she had not had another child. She said, “Everyone is always asking about my next issue (offspring). I do not feel normal with only two children. I can’t tell them why we are not having more issues (children).” In addition to the social pressure to have more children, she also expressed a strong desire for a daughter. Regarding the risks of contracting HIV herself, she simply said, “My husband is healthy now that he is taking his drugs. If I become infected I will also take drugs.”

CYDI referred Ogechi to the doctor in charge of the ART clinic at FMC Owerri to make sure that she fully understood the medical risks to herself and the child not yet conceived. To this point in time, Ogechi has not had another child. But the explanation appears to have less to do with a greater understanding of the health risks than a change in her perception of her marriage, and particularly the behavior of her husband. Had Nnamdi not begun to get back to normal in ways she found reprehensible – resuming a pattern of extramarital relationships – there is no reason to think that she wouldn’t have continued to insist on another child. Parenthood and childbearing remain the paramount life projects for people in southeastern Nigeria. For people on ARVs – or married to someone on ART – having children is the most important path to normalcy.

## Back to Normal: "A Criminal on ARVs Is Still a Criminal"

For the staff at CYDI and others who counsel people living with HIV who now have access to ARVs it is often said that one of the goals of counseling is to get the person back to where they were the moment before they learned they were infected – that is, to get them to think again about life as project that they can still undertake with considerable normality. Through the cases already narrated, it should be clear that marriage and reproduction are, in southeastern Nigeria, the most important dimensions of forging a normal life. But the return to normality offered by ART involves many other aspects as well, including some that are inimical not only to personal and public health but also to the sensibilities of those trying to help.

Nnamdi's resumption of habitual extramarital sex is emblematic of the multiple forms of normalcy and the kinds of resurrected life projects that must be understood in the context of the availability and scaling up of antiretroviral treatment. In his public presentations of himself as an AsPoCa leader and in private conversations with friends at CYDI Nnamdi presents himself as a person who steadfastly adheres to a strict moral code. To people who know he is HIV-positive he speaks with great authority about all the things that one must do – and that he does – to protect the health of himself and others. But over time we began hearing stories from women who joined AsPoCa that Nnamdi was one of a number of men in the group who preyed upon single or newly widowed women, taking advantage of their vulnerability to entice them into sexual relationships. The stories of the women were confirmed by other men in the group. In several cases, pregnancies resulted among female AsPoCa members, though none were openly attributed to Nnamdi. His, wife, Ogechi, eventually came to CYDI to complain about her husband's behavior. She was now worried about protecting herself and no longer demanded another child. In the words of one CYDI staff member, "She no longer sees him as a loving husband for whom she will do anything in his time of need. Now she sees him as the man she's living in the same house with whose actions she cannot predict or control." In her words, "he is back to normal," with all the unhappy connotations it implied.

Many of the cases we observed attest to the multidimensional and sometimes negative aspects of the return to normalcy offered by ART. Whether these life projects are admirable or not, they often have implications for the health of the patient, their sexual partners, and their families. A particularly fascinating – if troubling – case involved a young man who stood out among the clinic population for his remarkable affluence. Eventually, he approached CYDI because he wanted help in finding an HIV-positive partner to marry. As he explained his desire for help we learned his story.

Uche came to CYDI's office with a common predicament. He wanted a wife and family, but given everything he knew about HIV/AIDS he felt he should marry a woman who was also infected so as not to risk another life. His problem, he said, was that none of the women at the FMC were of his standard. He wanted an attractive, educated and modern young woman, and he was hoping folks at CYDI would help. In fact, CYDI staff had introduced many HIV-positive people. The staff and organization shared and encouraged the view that partnerships between people living positively could mitigate some of the life-project problems created by the disease.

In telling his life story Uche confided that he earned his livelihood running an illegal international trade in narcotics. For nearly two decades it has been widely known that some Nigerians are heavily involved in moving illegal drugs, masterminding networks of carriers and distribution (Bayart 1999). Uche's trips to collect his ARVs at the FMC often coincided with a return from Asia. In one ironic twist, he described being jailed in the neighboring country of Niger when his flight unexpectedly stopped there. Apparently, he was traveling on a fake Niger passport and the authorities discovered it. In detention his ARV supply was exhausted and after a couple of months he began to get very sick. He told his guards he had HIV, but at first they did not believe him. Eventually, they had medical personnel run a test, which confirmed his infection. With some humor, he reported that guards wearing thick rubber gloves (he emphasized that they were cleaning gloves not medical gloves) escorted him to the airport to deport him to Nigeria. They handed over all his possessions, including his fake passport and commanded him never to return to Niger. The stigma of HIV, he said, probably saved his life.

The pressure on Uche to marry was intense. In contemporary southeastern Nigeria many young men are frustrated by the fact that they do not have the money to afford the high cost of bridewealth and all the other expenses of wedding. Uche's obvious wealth – which included houses in Lagos, Abuja and his village of origin and numerous expensive cars – meant that he had no excuse not to marry. His family was becoming impatient and his father even accused Uche of "selling his manhood" to achieve his wealth. In Nigeria, as in many parts of Africa, explanations of seemingly inexplicable wealth are often related to issues of reproduction (Geschiere 1997; Comaroff and Comaroff 1999). There is a strong belief that reproductive potential -- and even human life -- can be magically exchanged for fast wealth (Smith 2001b). Uche's father was indirectly accusing his son of a form of witchcraft and also expressing his awareness of the ill-gotten nature of his son's riches. The only way for Uche to placate his father and exonerate himself would be to marry and have children. He felt he dare not confess that he was HIV-positive.

The staff at CYDI found it ironic that someone involved in the deadly business of illegal drugs would be so concerned about making sure he found an HIV-positive life partner, but given that they were in support of this strategy for people living with HIV, they helped introduce Uche to a number of women. Adaku was about to graduate from university, and she also constantly pleaded with CYDI to help her find an HIV-positive husband. She was attractive to Uche and he was attractive to her. They began dating and for several months things seemed to be going well. He entertained her lavishly and provided plenty of money. But eventually Adaku returned to Owerri and said that she could no longer see Uche. She reported that he hit her, and she also believed that he was secretly having affairs with other women. Further, she suspected that he made his money in nefarious ways (as part of the confidentiality associated with counseling no one at CYDI told her he was a drug trafficker). She was afraid to be with him. In spite of his seemingly admirable desire to find a sero-positive spouse, he was obviously still doing bad things.

Partly as a result of this case, it became a common refrain among counselors and staff at CYDI to say “a criminal on ARVs is still a criminal.” This applied literally in the case of Uche, but figuratively to every other person whose future was restored by ART. The experience of learning one is HIV-positive, confronting biological and social death, and then having the possibility of life renewed by effective treatment sometimes results in significant life changes – including changes that individuals perceive as positive, such as with regard to religious faith, commitment to family, or personal behavior. But equally common, indeed more common in our experience, is that ART enables people to resume life trajectories and pursue social goals that were priorities before they learned they were infected. Not all of these goals, of course, are noble.

Another memorable example involved a young man named Okwu who learned he was HIV-positive not too long after his older brother died of AIDS. Okwu and his late brother were his parents’ only sons and he felt he could never tell his parents that he too was infected because it would “kill them.” Okwu reacted to his diagnosis with anger and vengeance and turned his fury on women (cf. Leclerc-Madlala 1997). He resolved “to take women with him,” and he began having as much unprotected sex as he could. But when he later enrolled in the ART program, he realized he could live. After hearing the many messages about living positively from FMC counselors and CYDI staff, Okwu started to think differently. One day he asked to see a counselor, reporting that some of the “useless talk” at the FMC had begun to affect him.

His devilish plan to infect women had resulted in his co-infection with HIV1 and HIV2, a fact he believed may have been God’s way of punishing him. Now that Okwu was on ART and could foresee a future he wanted to get married. He wished to find a way to have his girlfriend tested before proposing marriage, but could not think of how to engineer it without revealing his own status. After multiple counseling sessions, he finally decided to tell her. When he revealed his status she also confessed that she was HIV-positive. He accused her of deception, but she retorted, “What about you?” For a while they broke up, each angry over their mutual deception, but in the end they reunited and married. The staff at CYDI couldn’t help but comment that they deserved each other. Eventually, Okwu resumed his womanizing and began selling some of his antiretroviral drugs (before the change in policy to provide free drugs, people in the government subsidized program could sell their medicines at a huge profit on the open market). In the end, he got sick and died.

## Conclusion

The life projects restored by ART are not, obviously, all positive. But for most people who are enrolled in Nigeria’s expanding antiretroviral therapy program the opportunity to resume a normal life is cherished and made the most of. In our experience, the most valued part of a resurrected life is the chance to marry (or remarry) and have children. While the vast majority of people on ARVs at the FMC-Owerri are mindful of the continued risks to themselves and others, and committed to keeping themselves and their loved ones safe, the physical risks to personal and public health are factored into a larger equation in which the very reasons for being alive are always paramount. In southeastern Nigeria, marriage and parenthood, the principal tasks of biological and social reproduction, reign supreme in the hierarchy of social expectations and individual aspirations.

For many people on ARVs the dilemmas of how to marry and make families while living with HIV are resolved, or at least addressed, by seeking partners from within the communities created through treatment and the support groups that been established as a result. At the FMC-Owerri AsPoCa has been a principal meeting ground for people seeking sexual partners, possible spouses, and eventually pregnancy and children. Several other support groups have been established in the region and anecdotal reports suggest that they have also become arenas for sexual networking and marriage markets. As in the larger society, not all of what goes on in the support group is laudable. The inequalities of age, gender and social class are reproduced, and even more troubling, people's vulnerable emotional status is sometimes exploited. But overall, the emerging communities of people living with HIV seem to be a positive development, enabling people to forge life projects, including reproductive projects, in ways that make it easier to address both ethical and medical realities.

Of course not everyone who is HIV-positive can or will find lust, love, or marriage within the support groups. The lives of people living with HIV remain naturally intertwined with the wider population of people who do not know their status. Life projects, especially reproductive life projects, continue to pose ethical predicaments, public health risks, and existential dilemmas. Whether, when, and how to disclose one's HIV status; how to marry and have children in ways that meet social expectations and achieve personal ambitions; and how to stay healthy and on drugs while doing all this – these are priority issues for people living with HIV who have been provided another chance at life by the availability of ART.

As the cases described above have illustrated, while the availability of drugs has commuted the social and biological death sentences previously associated with HIV/AIDS in Nigeria, the scaling up of treatment has not yet significantly reconfigured the landscape of stigma. As a result, people on ARVs continue to try to manage their treatment mostly in secret. In many cases the resurrection of reproductive life projects can prove to be an obstacle to adhering to therapy and vice-versa. For people who rely on antiretroviral medicines to live, the continuing stigma of the disease means that the very drugs which have restored their futures also threaten to undermine their most precious life projects. The drugs themselves, so valued for their physical effects, are reminders of the enduring difficulties and discrimination associated with HIV/AIDS.

Based on the findings from this ethnographic examination of a small population of people on ART in southeastern Nigeria, organizations that provide treatment and counseling face many challenges in promoting behaviors that are in the interest of both their individual patients and broader public health. The experiences at FMC-Owerri and CYDI suggest that it is crucial to acknowledge, understand, and support the restoration of life projects. Given how important sexual relationships, marriage, and reproduction are in southeastern Nigeria – and the likelihood that these priorities will be similar in many other societies – clinicians, counselors, and other public health personnel will need to be mindful that their messages and advice will only be heeded if they enable these life projects. There is probably no way to avoid the fact that the fulfillment of personal aspirations and social expectations sometimes directly conflicts with public health interests. But as many of the stories described here attest, people on ART are highly attuned to these issues and most take all of this into account to the extent that they can if they are given a chance. The life projects of people on ARVs are complicated, contradictory, and messy. Perhaps we should not expect much different if one of the glories of ART is that it allows people infected with HIV to live normal lives.

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